CITY OF MARIETTA/BOARD OF LIGHTS AND WATER

APPLICATION FOR FAMILY AND MEDICAL LEAVE OF ABSENCE

EMPLOYEE INFORMATION

NAME: _____
(LAST) (FIRST) (MIDDLE)

SOCIAL SECURITY NUMBER: _____ EMPLOYMENT DATE: _____

DEPARTMENT:_____ DIVISION: _____

LEAVE INFORMATION

I hereby request family or medical leave of absence for the following reason:

☐ Birth of a child

☐ Placement of a child with employee for adoption or foster care

☐ Serious Health Condition of Spouse

☐ Serious Health Condition of Parent

☐ Serious Health Condition of Child

☐ Serious Health Condition of Employee

**** Attach medical certification to support your request for leave for serious health conditions. ****

OTHER PERTINENT INFORMATION

Length of leave: _____ Effective Date: _____

Return Date: _____ Are you a Key Employee? ☐ Yes ☐ No

Have you taken family and/or medical leave within the last twelve months? ☐ Yes ☐ No

Do you have accrued vacation leave? ☐ Yes ☐ No Sick Leave? ☐ Yes ☐ No

SIGNATURE

I have read and understand the Family and Medical Leave Policy and agree to abide by the conditions and requirements of the policy should my leave of absence request be granted.

_____ _____
EMPLOYEE DATE

AUTHORIZATION

_____ _____
DEPARTMENT HEAD DATE DIRECTOR OF HUMAN RESOURCES DATE

☐ APPROVED ☐ DISAPPROVED

CITY OF MARIETTA/BOARD OF LIGHTS AND WATER
CERTIFICATION OF PHYSICIAN OR PRACTITIONER

(To be completed by health care provider)

1. Employee's name: _____

2. Patient's name (if different from employee): _____

3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.
   (1) ___ (2) ___ (3) ___ (4) ___ (5) ___ (6) ____, or none of the above .__

4. Describe the medical facts that support your certification, including a brief statement on how the medical facts meet the criteria of one of these categories: _____
   _____

5. a. State the approximate date the condition commenced and the probable duration of the condition (and also the probable duration of the patient's present incapacity[2] if different):
   _____

   b. Will it be necessary for the employee to work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in Item 6 below)? _____Yes _____ No. If yes give the probable duration: _____

   c. If the condition is a chronic (condition #4) or pregnancy, state whether the patient is presently incapacitated[2] and the likely duration and frequency of episodes of incapacity[2]: _____
   _____

6. a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments: _____
   _____

   If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:
   _____

   b. If any of these treatments will be provided by another provider of health services (e.g.,physical therapist), please state the nature of the treatments: _____

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[1] Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

[2] "Incapacity," for purpose of the FMLA, is defined to mean inability to work, attend schools, or perform other regular daily activities due to the serious health condition, treatment for it, or recovery from it.

c. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment): _____

7. a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition,) is the employee able to perform work of any kind? _____ Yes _____ No

b. If able to perform some work, is the employee unable to perform one or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions)? ____ Yes _____ No. If yes, please list the essential functions the employee is unable to perform: _____

_____

c. If a and b do not apply, is it necessary for the employee to be absent from work for treatment? _____ Yes _____ No

8. a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs, safety, or for transportation? _____ Yes _____ No

b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? _____ Yes _____ No

c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need: _____

_____

_____ _____

(Signature of Health Care Provider) (Type of Practice)

_____ _____

Address (Telephone Number)

To be completed by the employee needing family leave to care for a family member:

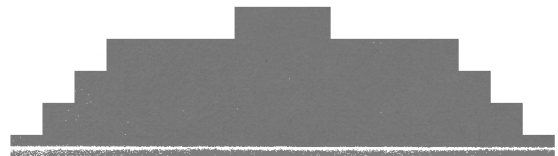
State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule: _____

_____

_____

_____ _____

(Employee Signature) (Date)



A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. **Hospital Care**

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity[2] or subsequent treatment in connection with, or as a consequence of such inpatient care.

2. **Absence Plus Treatment**

(a) A period of incapacity[2] of more than three consecutive calendar days (including any subsequent treatment or period of incapacity[2] relating to the same condition) that also involves:

(1) Treatment[3] two or more times by a health care provider, a nurse, or physician's assistant under direct supervision of a health care provider or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by a health care provider, or

(2) Treatment by a health care provider on at least one occasion that results in a regiment of continuing treatment[4] under the supervision of the health care provider.

3. **Pregnancy**

Any period of incapacity due to pregnancy or for prenatal care.

4. **Chronic Conditions Requiring Treatments**

A chronic condition that:

(1) Requires periodic visits for treatment by a health care provider or a nurse or physician's assistant under the direct supervision of a health care provider:

(2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(3) May cause episodic incapacity rather than a continuing period of incapacity[2] (e.g., asthma, diabetes, epilepsy, etc.)

5. **Permanent/Long-term Conditions Requiring Supervision**

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[2] "Incapacity," for purpose of the FMLA, is defined to mean inability to work, attend schools, or perform other regular daily activities due to the serious health condition, treatment for it, or recovery from it.

[3] Treatment includes examinations to determine if a serious condition exists and evaluations of the condition. Treatment does not include routine physical examination, or dental examinations.

[4] A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) of therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include taking over-the-counter medications such as aspirin, antihistamines, or salves and bed rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

A period of incapacity[2] that is permanent or long term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment from a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. **Multiple Treatments (Nonchronic Conditions)**

Any period of absence to receive multiple treatments (including any period of recovery from them) by a health care provider or a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury or for a condition that would be likely to result in a period of incapacity[2] of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), or kidney disease (dialysis).

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[2] "Incapacity," for purpose of the FMLA, is defined to mean inability to work, attend schools, or perform other regular daily activities due to the serious health condition, treatment for it, or recovery from it.